STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295041	A. BUILDING _____ B. WING _____	06/27/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF GREEN VALLEY	100 DELMAR GARDENS DRIVE HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare re-certification survey and complaint investigation conducted at the facility from June 19, 2008 through June 27, 2008. The census at the time of the survey was 184 residents. The total sample size was 31, including 3 closed records. The following complaints were investigated: Complaint # NV18537 - Substantiated (F Tag #257) Complaint # NV16147 - Unsubstantiated Complaint # NV16577 - Unsubstantiated Complaint # NV17290 - Unsubstantiated Complaint # NV17563 - Unsubstantiated The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified at the time of the survey:	F 000		
F 257 SS=E	483.15(h)(6) ENVIRONMENT- TEMPERATURE The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 257		9/3/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295041	A. BUILDING _____ B. WING _____	06/27/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF GREEN VALLEY	100 DELMAR GARDENS DRIVE HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 257	Continued From page 1	F 257		

review, the facility failed to maintain its Unit four area at a comfortable temperature.

Findings include:

Observation

On 06/19/08 at 10:00 AM, temperature readings were taken in the following areas of the facility's Unit four:

Unit four dining room, room 1301 in the hallway, between rooms 1203-1205 in the hallway, inside room 1203, between rooms 1103-1105 in the hallway, inside room 1101, and Unit four nurses' station. With one exception, temperatures were 84 degrees Fahrenheit at each location. The dining room reading was 80 degrees Fahrenheit.

Interview

On 06/19/08 at 11:30 AM, the Director of Nursing revealed the air conditioning went out on 06/16/08. Seventeen residents were affected on Unit four.

On 06/19/08 at noon, the maintenance director revealed there was a discrepancy between the supply and return temperatures on the air conditioning unit from their usual reading. This discrepancy started the previous weekend. Swamp coolers were initiated on Unit four on 06/18/08.

On 06/19/08 between 11:30 AM and noon, visitors in the 1200 hallway indicated the air conditioning was off and on for a few weeks. A resident indicated she "sleeps at night, but it's too hot." A second resident in the area indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295041	A. BUILDING _____ B. WING _____	06/27/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF GREEN VALLEY	100 DELMAR GARDENS DRIVE HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 257	Continued From page 2 she perspired more and had a cold compress on her head. Document Review A chiller daily log sheet indicated the return and supply temperatures rose to 75 and 73 degrees Fahrenheit from 63 and 59 degrees Fahrenheit respectively at 2:45 PM on 06/12/08.	F 257		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide the necessary care and services to attain or maintain the highest practical physical well-being, in accordance with the comprehensive assessment and plan of care for 1 of 31 residents (#6). Findings include: Resident #6 Resident #6 was an 83 year old female who was re-admitted to the facility on 11/13/07 with diagnoses including unspecified Acute Renal Failure, Dementia with Behavioral Disturbances, Unspecified Psychosis, Atrial Fibrillation, and history of Urosepsis requiring hospitalization and	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295041	A. BUILDING _____ B. WING _____	06/27/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF GREEN VALLEY	100 DELMAR GARDENS DRIVE HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 3 Post Coronary Bypass Graft. Record Review The Care Plan for Resident #6 dated 3/05/08, indicated a potential problem was urinary tract infection. The approach indicated to monitor for concentrated urine, foul odor, cloudiness, urgency burning or pain with urination, fever, and to notify the resident's physician when necessary. Nurse's notes for Resident #6 dated 06/04/08 at 8:00 PM, indicated a urine dipstick was done and tested positive for leukocytes. The resident's urine specimen was described as, "slightly cloudy, with slight foul odor and small brown sediment." A urinalysis (U/A) and a culture and sensitivity (C/S) were obtained and sent to the laboratory on 06/04/08 at 8:00 AM. The urinalysis for Resident #6 dated 06/05/08, indicated the urine specimen contained several abnormal readings including one plus (+) blood; trace bacteria; leukoesterase 3 +; 5 to 10 red blood cells (RBC) and 10 to 20 white blood cells (WBC). The report indicated the u/a was faxed to the physician's office on 06/05/08 at 7:30 PM. Nurse's notes dated 06/11/08, 06/17/08, and 06/24/08 indicated Resident #6's physician was in the facility and no new orders were written. Physician's progress notes for Resident #6 revealed no documentation that the physician had reviewed the U/A or the C/S and whether treatment was indicated. Interview	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295041	A. BUILDING _____ B. WING _____	06/27/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF GREEN VALLEY	100 DELMAR GARDENS DRIVE HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 4 On 6/24/08 in the afternoon, the Director of Nursing (DON) was asked why there was no documentation in the medical record concerning follow-up of the U/A and the C/S for Resident #6. The DON indicated the resident's physician was in the facility and she would speak to him. Record Review On 6/24/08 a repeat U/A and C/S was ordered by the physician for Resident #6. The results of the U/A posted in the medical record on 6/25/08 indicated the specimen was slightly cloudy, with two + blood; 5-10 RBC; 10-20 WBC; 3-5 epithelial cells; and rare bacteria. Nurse's notes dated 06/25/08, indicated the results of the U/A were received by the facility and telephoned to the resident's nurse practitioner. Physician's orders dated 06/25/08, indicated "Cipro 250 milligrams twice a day for three days until the C/S was back." The facility failed to follow-up on an abnormal urinalysis and culture and sensitivity resulting in a delay in treatment.	F 309		
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295041	A. BUILDING _____ B. WING _____	06/27/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF GREEN VALLEY	100 DELMAR GARDENS DRIVE HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to assess according to its policy, implement interventions to reduce risks, monitor interventions for effectiveness, and modify interventions when necessary to prevent falls in 1 of 28 residents (#20). Findings include: Resident #20 Resident #20 was admitted 01/05/07 with the following diagnoses: Hypercholesterolemia, Hypertension, Reflux, Depression, Airway Obstruction and Fall History. Observation On 06/27/08 at 11:00 AM, a red butterfly symbol was observed by Resident #20's room entrance. Interview On 06/27/08 at 1:00 PM, the Director of Nursing (DON) yielded the following information about post-fall protocols: 1. Nursing completed a quarterly fall risk assessment, and a score of 10 or higher indicated a high risk resident, symbolized by a red butterfly placed at a resident's room entrance. 2. The unit's charge nurse completed a post-fall assessment form after each fall. 3. Nursing and physical therapy departments completed the therapy screen for falls form to	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295041	A. BUILDING _____ B. WING _____	06/27/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF GREEN VALLEY	100 DELMAR GARDENS DRIVE HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 6 collaborate on possible new interventions. 4. The unit's charge nurse was supposed to update a resident's care plan after each fall. 5. If the nurse did not update a care plan, the DON would speak to the nurse and remind the nurse to implement Falls Protocol Intervention Guidelines placed on each unit. 6. The DON completed a resident restraint reduction assessment after each fall and she would conduct fall rounds. The DON indicated the restraint reduction assessment addressed falls also; this was the interdisciplinary fall investigation committee form referred to in the fall risk/prevention program dated 03/05/08. Record Review and Document Review A record and document review regarding post-fall follow-up revealed the following information: 1. According to the facility's fall risk/prevention program policy dated 03/05/08, a red butterfly symbol was placed by a resident's door indicating a high fall risk resident. According to the facility's fall reporting protocol dated 03/30/07, a charge nurse and a physical therapist completed a therapy screen for falls after each fall. 2. A post-fall assessment form indicated the following: - dated 07/30/07, indicated Resident #20 had a history of falls, poor safety awareness, and a lack of call light use. The chart lacked documentation of a post-fall therapy screen. - dated 9/18/07, indicated Resident #20 had a	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295041	A. BUILDING _____ B. WING _____	06/27/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF GREEN VALLEY	100 DELMAR GARDENS DRIVE HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 7	F 323		

history of falls, a lack of call light use, and the form indicated Resident #20 actually fell on 09/12/07. The chart lacked documentation of a post-fall therapy screen.
- dated 10/15/07, indicated Resident #20 had a history of falls, poor safety awareness, lack of call light use, and non-compliance with ordered personal alarm use. The chart lacked documentation of a post-fall therapy screen.
- dated 11/19/07, indicated Resident #20 had a history of falls, poor safety awareness, and a lack of call light use. The chart lacked documentation of a post-fall therapy screen. Resident #20's fall care plan dated 11/12/07, alerted staff to Resident #20's continued non-compliance with ordered personal alarm use, yet staff failed to modify the care plan.

3. Each treatment kardex dated from 12/01/07 to 06/27/08 continued to indicate staff would use a personal alarm on Resident #20's wheelchair and bed; however, the chart lacked documented alarm monitoring. The facility's falls protocol intervention guidelines, revised on 03/30/07, indicated alarms should be used for short term trials up to 90 days.

4. According to the facility's high risk for fall guidelines dated 03/04/08, residents with a red butterfly symbol by their rooms were "not to be left alone on the toilet."

5. A post-fall assessment form dated 12/27/07, indicated Resident #20 sustained a 1 inch laceration on the back of his head trying to transfer from the toilet to his wheelchair. The form failed to indicate personal alarm use or behavior(s) contributing to the fall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295041	A. BUILDING _____ B. WING _____	06/27/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF GREEN VALLEY	100 DELMAR GARDENS DRIVE HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 8	F 323		

6. A post-fall assessment form dated 03/04/08, indicated Resident #20 had a history of falls and a lack of call light use.

7. An in-house quality assurance form dated 03/27/08, indicated Resident #20 did NOT have poor safety awareness.

8. Post-fall assessment forms indicated the following:
- dated 04/26/08, indicated Resident #20 had a history of falls, poor safety awareness, and a lack of call light use. The chart lacked documentation of a post-fall therapy screen.
- dated 05/17/08, indicated Resident #20 had a history of falls, poor safety awareness, and a lack of call light use; however, it also indicated he used the call light in this instance. The chart lacked documentation of a post-fall therapy screen. According to the facility's certified nursing assistant (CNA) activities of daily living documentation tool dated 05/17/08, Resident #20 was independent and "no help or oversight [was] provided" for transferring or toileting.
- dated 05/23/08, indicated Resident #20 used the call light and was observed by a CNA "sitting down on the floor next to his reclining chair." He was returning from the bathroom. The form failed to indicate personal alarm use or behavior(s) contributing to the fall. The chart lacked documentation of a post-fall therapy screen. According to the facility's certified nursing assistant (CNA) activities of daily living documentation tool dated 05/23/08, resident #20 was independent and "no help or oversight [was] provided" for transferring or toileting.
- dated 06/19/08, indicated Resident #20 had a history of falls, poor safety awareness, and a lack of call light use; however, it also indicated he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295041	A. BUILDING _____ B. WING _____	06/27/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF GREEN VALLEY	100 DELMAR GARDENS DRIVE HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 9	F 323		

used the call light from the bathroom in this instance. The chart lacked documentation of a post-fall therapy screen. According to the facility's certified nursing assistant (CNA) activities of daily living documentation tool dated 06/19/08, resident #20 was independent and "no help or oversight [was] provided" for transferring or toileting.
- According to the facility's high risk for fall guidelines, dated 03/04/08, residents with a red butterfly symbol by their rooms were "not to be left alone on the toilet." One of the resident's care plan interventions stated "assist with transfers for safety."

9. Staff updated the fall care plan for Resident #20 four times since 11/12/07. Resident #20 had seven falls since the original care plan dated 11/12/07. The fall risk/prevention program policy dated 03/05/08, indicated "interventions are to be updated on the resident care plan."
Care plan updates stated the following:
- 03/04/08, indicated "call light within reach at all times, safe environment, inform resident to use call light when needing assist." Safety was also listed as an intervention on the 11/12/07 care plan. This intervention was not specific and measurable. Informing the resident to use the call light was repeatedly used as an intervention as documented on previous post-fall assessment forms with repeated non-compliance. The facility failed to modify its interventions after proving ineffective.
- 04/26/08, indicated "frequent reminder to call for assistance, monitor frequently for safety, provide safe environment." Frequent reminder to call for assistance was repeatedly used as an intervention as documented on previous post-fall assessment forms with repeated non-compliance. The facility failed to modify its interventions after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295041	A. BUILDING _____ B. WING _____	06/27/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF GREEN VALLEY	100 DELMAR GARDENS DRIVE HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 10 proving ineffective. Monitoring frequently for safety was not a specific and measurable intervention. Provide a safe environment is not a specific and measurable intervention. 10. The fall risk/prevention program policy dated 03/05/08, indicated "the interdisciplinary fall investigation committee form will be filled out during fall rounds for quality assurance purposes." Resident #20 had four falls after 03/05/08; the facility failed to document the four falls since 03/05/08 on this quality assurance form. The facility failed to follow its policies regarding therapy screens, quality assurance monitoring, and resident care plans. The facility failed to initiate new interventions and/or modify its interventions after proven ineffective. The resident had a history of head lacerations from falls in this facility (01/13/07 and 12/27/07).	F 323		
F 332 SS=D	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure it was free of medication error rates of less than 5 percent. Fifty three medication passes were observed and 5 errors were noted for an error rate of 9.4% Findings include:	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295041	A. BUILDING _____ B. WING _____	06/27/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF GREEN VALLEY	100 DELMAR GARDENS DRIVE HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 11	F 332		

Resident #26

Resident #26 was an 87 year old female admitted on 7/27/07 with medical diagnoses including the following: Chronic Airway Obstruction, Atrial Fibrillation, Unspecified Essential Hypertension, Cardiomegaly, Cardiac Pacemaker In Situ, Osteoporosis, Long-term Anticoagulant Use, and Glaucoma.

Observation

On 6/25/08 at 7:55 AM, a medication pass was observed with the Licensed Practical Nurse (LPN) administering scheduled 8:00 AM medications to Resident #26. Resident #26 did not receive the 8:00 AM scheduled medications Furosemide/Lasix, Metoprolol/Lopressor, Calan SR /Verapamil SR, and Megestrol/Megace. The Megestrol/Megace was not administered because it was "not available." The potassium chloride/K-Dur 10 meq (milliequivalent) was administered.

The LPN was observed monitoring the resident's blood pressure (BP) at the right wrist and stated the reading was "109/62." The LPN indicated she would hold the "Lasix, Lopressor, and Verapamil" due to the low BP.

Interview

On 6/25/08 at 10:30 AM, a Nursing Care Coordinator (LPN) indicated medication administration involved following procedures and parameters, rechecking blood pressure, use of nursing judgement, and checking with the RN (registered nurse) house supervisor as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295041	A. BUILDING _____ B. WING _____	06/27/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF GREEN VALLEY	100 DELMAR GARDENS DRIVE HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 12 Record Review The physician's orders dated 6/1/08 for Resident #26 listed the following medication orders: - "Lopressor 50 mg (milligrams) po (by mouth) BID (twice daily) HTN (hypertension) HOLD FOR SBP (systolic blood pressure) < 100." - "Verapamil 180 mg po QD (every day) HTN HOLD FOR SBP < 100." - "Lasix 20 mg po Q AM (every morning)." - "K-DUR 10 meq 1 po Q AM W/ (with) LASIX." - "Megace 400 mg (10 cc) (cubic centimeter) po BID APPETITE STIMULANT." The omission of 4 (Lopressor, Verapamil, Lasix, Megace) of the 8:00 AM medications did not follow the parameters written in the physician's orders and the administration of 1 (K-DUR) of the 8:00 AM medications did not follow the parameters written in the physician's orders.	F 332		
F 431 SS=E	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295041	A. BUILDING _____ B. WING _____	06/27/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF GREEN VALLEY	100 DELMAR GARDENS DRIVE HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 13 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to establish a system for reconciling stored drugs/biologicals in locked compartments and refrigerators, labeled in accordance with currently accepted professional principles that included expiration dates for emergency supplies of IV (intravenous) fluids, IV medications, controlled injectable medications, controlled oral medications, oral antibiotics, oral medications, and injectable insulin. Findings include: Observation On 6/24/08 at 9:45 AM, the medication cart on the 400 hall was not locked.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295041	A. BUILDING _____ B. WING _____	06/27/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF GREEN VALLEY	100 DELMAR GARDENS DRIVE HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 14 On 6/24/08 at 1:35 PM, the locked box in the refrigerator in the small Unit 1 medication room was not secured to the refrigerator. The LPN (licensed practical nurse) lifted the locked box out of the refrigerator to reveal the contents of the box which included 4 boxes of Lorazepam/Ativan 2mg/mL (milligram per milliliters) and one 10 mL vial of Lorazepam/Ativan 2mg/mL containing 8.25 mL's. On 6/24/08 at 1:55 PM, the refrigerator in the larger 2nd medication room on Unit 1 contained 2 multi-dose vials of insulin: Novolin R (regular) 100 units per mL (milliliter) 10 mL's, Regular Human Insulin Injection, control # SZF0048, expiration date 5/2008 and Novolin R 100 units per mL 10 mL's, Regular Human Insulin Injection, control # SZF0048, expiration date 5/2008. On 6/24/08 at 3:25 PM, the Sure-Med medication administration machine in the larger 2nd medication room on Unit 1 contained the following expired medications: - 3 vials of Ceftazidime/Fortaz 1G (gram), NDC 0173 0378-10, Lot B093, expiration date 1/2008, - 4 tablets of Dexamethasone/Decadron 4 mg (milligram), Lot 457938A, expiration date 11/30/2007, - 2 carb-jet injections of Diazepam/Valium 10 mg/2 mL (milliliter), Hospira 47660 LL, expiration date 5/1/2008, - 3 tablets of Diflucan/Fluconazole 100 mg, Lot 357575V, expiration date 3/30/2008, - 1 tablet of Hydrocodone Bitartrate/APAP 7.5/500 mg, # 0358J50245, expiration date 5/31/2008, - 1 injectable dose of Hydromorphone HCL 4 mg/ mL, # 39620LL, expiration date 1/30/2008,	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295041	A. BUILDING _____ B. WING _____	06/27/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF GREEN VALLEY	100 DELMAR GARDENS DRIVE HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 15 - 5 dose vials of Ipratropium Bromide, 0.5 mg/2.5 mL 0.02 % solution, expiration date 2/2008, - 5 tablets of Metronidazole 250 mg, # 3335012A, expiration date 3/20/2008, - 5 tablets of Phenobarbital 15 mg, # D 0114, expiration date 12/20/2007, - 5 injectable doses of Phenytoin Sodium 100 mg in 2mL, #46-507-DK, expiration date 4/1/2008, - 3 bags of Sodium Chloride 0.9% Intravenous fluid 100 mL's, Baxter, expiration date 8/2007, - 5 tablets of Sulfamethoxazole-Trimethoprim 800 mg -160 mg, # 823051, expiration date 2/20/2008, - 3 vials of Triamcinolone-Acetonide 40 mg/1 mL Injection, 5 mL vial, # 6812058, expiration date, 1/2008, - 1 tablet of Warfarin Sodium 4 mg, # 408744012, expiration date 6/30/2008, and - 3 tablets of Warfarin Sodium 2.5 mg, #408325013T, expiration date 5/20/2008. Interview On 6/24/08 at 1:55 PM, Employee #2 reported that Spectrum Pharmacy did "spot checks" for expired medications and the night nurse was responsible for checking "every night" for expired medications in the medication room refrigerator. On 6/24/08 at 3:25 PM, at the request of Employee #2 the Spectrum Pharmacy Nurse Liaison, was able to access the Sure-Med medication administration machine in the 2nd medication room on Unit 1. The Spectrum Pharmacy Nurse Liaison indicated that the "drivers" who stocked the Sure-Med medication administration machine were responsible for checking for expired medications and stated, "The drivers should check when they refill" the	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295041	A. BUILDING _____ B. WING _____	06/27/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF GREEN VALLEY	100 DELMAR GARDENS DRIVE HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 16 medications. Document Review The policy and procedure titled "Medication Administration," number M-4, page 2 of 3, effective date: rev. 5/2007, stated the following regarding expired medications: "Expired or discontinued medication from the pharmacy is to be returned to the D.O.N. (director of nursing) for destruction. Controlled medications that have expired or discontinued, along with expired stock drugs will be destroyed in the facility."	F 431		
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation and document review, the facility failed to ensure staff washed their hands after every direct resident contact for 2 of 4 residents (#27, #28). Findings include: Observation On 6/24/08 at 4:30 PM, Employee #21 was observed administering a protein powder to a resident via GT (gastrostomy tube) in the 400 hallway. After the administration, Employee # 21	F 444		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295041	A. BUILDING _____ B. WING _____	06/27/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF GREEN VALLEY	100 DELMAR GARDENS DRIVE HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 444	Continued From page 17 was observed at the sink rubbing her hands under running water and drying her hands with paper towels. Employee # 21 was not observed using soap to wash her hands. On 6/24/08 at 4:35 PM, Employee #21 was observed administering a medication to a resident in the 400 hallway. After the medication administration, Employee #21 was observed at the sink rubbing her hands under running water and drying her hands with paper towels. Employee #21 was not observed using soap to wash her hands. On 6/25/08 at 7:15 AM, the soap dispensers in rooms 400 and 401 were observed, soap was available and dispensed from both dispensers. Document Review The policy and procedure titled "Medication Administration," number M-4, page 3 of 3, effective date: rev. 5/2007, stated the following: "19. Wash your hands before and after each different resident contact."	F 444		